

NEW HAMPSHIRE INSTITUTE FOR THERAPEUTIC ARTS

School of Massage Therapy

153 LOWELL ROAD
HUDSON, NEW HAMPSHIRE 03051
603 882 3022

27 SANDY CREEK ROAD
BRIDGTON, MAINE 04009
207 647 3794

APPLICATION FOR ADMISSION

NAME _____ DATE _____

HOME ADDRESS _____

MAILING ADDRESS _____

HOME PHONE _____ WORK PHONE _____ E MAIL _____

DATE OF BIRTH _____ SOC. SEC. # _____ SEX _____

PRESENT OCCUPATION _____

DESCRIPTION OF WORK AND EMPLOYMENT BACKGROUND _____

EDUCATIONAL BACKGROUND AND/OR DEGREES HELD* _____

PERSONAL INTERESTS _____

PLEASE STATE YOUR MOTIVATION AND INTEREST IN STUDYING MASSAGE THERAPY _____

SIGNATURE _____ DATE _____

Applications for Autumn Program must be submitted by August 1 and for Winter program by December 1.

Please indicate which program you are applying for: September January

The application fee is \$35., and a check or money order for that amount must accompany this form.

*Please send official transcript(s), diploma(s), and/or certification(s).

APPLICATION FEE RECEIVED _____

DATE _____

ADMINISTRATOR INITIALS _____

MEDICAL HISTORY

PLEASE COMPLETE THE FOLLOWING FORM, INDICATING ANY CONDITIONS YOU NOW HAVE OR HAVE HAD IN THE PAST.

- | | | |
|--|--|--|
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> BRUISE EASILY | <input type="checkbox"/> EPILEPSY |
| <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> JOINT PAIN | <input type="checkbox"/> HEADACHES |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEMOPHILIA | <input type="checkbox"/> IMMUNE DISORDER |
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> SEIZURES | <input type="checkbox"/> ARTHRITIS |

DO YOU HAVE ANY MUSCULOSKELETAL PROBLEMS?

- YES NO

PLEASE SPECIFY _____

VERTEBRAL/DISC PROBLEMS? _____

ARE ANY OF THESE CONDITIONS EXACERBATED BY ANY PARTICULAR MOVEMENTS? _____

HAVE YOU HAD ANY SURGERIES? YES NO

PLEASE SPECIFY _____

ARE THERE ANY OTHER INJURIES OR ILLNESSES WE SHOULD BE AWARE OF? _____

PLEASE LIST ANY MEDICATIONS YOU TAKE REGULARLY: _____

THE ABOVE INFORMATION IS CONFIDENTIAL AND IS MAINTAINED AS PART OF STUDENT FILE.

TO THE BEST OF MY KNOWLEDGE I HAVE PROVIDED AN ACCURATE HEALTH HISTORY:

SIGNATURE _____ DATE _____

APPLICATION INSTRUCTIONS:

- APPLICATION SUBMISSION SHOULD BE ACCOMPANIED BY A \$35.00 APPLICATION FEE AND PROOF OF HIGH SCHOOL GRADUATION (OFFICIAL TRANSCRIPT, DIPLOMA OR CERTIFICATION EVIDENCING MINIMUM H.S. EDUCATION OR OTHER ADVANCED DEGREE).
- YOUR COMPLETED APPLICATION MAY BE SENT TO THE SCHOOL LOCATION YOU ARE PLANNING TO ATTEND. THE ADDRESS OF EACH SCHOOL IS PROVIDED AT THE TOP OF THE APPLICATION.
- PLEASE REMEMBER TO CHECK THE BOX FOR THE PROGRAM YOU ARE APPLYING FOR: EITHER SEPTEMBER OR JANUARY.
- WE LOOK FORWARD TO RECEIVING AND REVIEWING YOUR APPLICATION.